



STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
20425 72nd Avenue S, Suite 400, Kent, WA 98032-2388

April 28, 2016

Kennydale Hills AFH LLC
KENNYDALE HILLS AFH LLC
1615 EDMONDS AVE NE
RENTON, WA 98056

RE: KENNYDALE HILLS AFH LLC License #752955

Dear Provider:

The Department completed a follow-up inspection of your Adult Family Home on April 27, 2016 for the deficiency or deficiencies cited in the report/s dated March 17, 2016 and found no deficiencies.

The Department staff who did the inspection:
Olga Petrov, Licensor

If you have any questions please, contact me at (253) 234-6007.

Sincerely,

Delores Usea, Field Manager
Region 2, Unit G
Residential Care Services

WAC 388-76-10340 Preliminary service plan. The adult family home must ensure that each resident has a preliminary service plan that includes:

- (1) The resident's specific problems and needs identified in the assessment;
- (2) The needs for which the resident chooses not to accept or refuses care or services;
- (3) What the home will do to ensure the resident's health and safety related to the refusal of any care or service;
- (4) Resident defined goals and preferences; and
- (5) How the home will meet the resident's needs.

This requirement was not met as evidenced by:

Based on record review and interview, the Entity Representative (ER) failed to ensure 1 of 2 sampled residents (Resident #5) had a preliminary service plan. This placed Resident #5 at risk of not having her immediate care needs met.

Findings include:

Interview and records review occurred on 3/15/16.

About 8:30 AM, observation found Resident #5 in her [REDACTED] waiting for her ride. Resident #5 was absent from the home for the time of the inspection.

At the entrance interview, the ER said Resident #5 admitted to the home on [REDACTED] 16. The ER said Resident #5 had diagnosis of [REDACTED] that affects [REDACTED]. The resident needed assistance with transfers and medications. The ER said Resident #5 had three episodes of falls since her move to the home. The ER said Resident #5 fell from her [REDACTED] when she attempted to self-transfer to her wheelchair (WC) and fell twice from her bed.

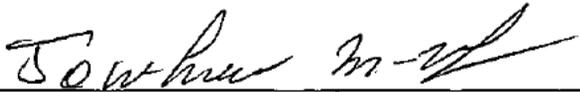
Resident #5's 3/09/16 assessment showed the resident had diagnoses of [REDACTED]. The assessment indicated Resident #5 needed medication assistance, had [REDACTED] catheter, was non-weight bearing, depended on caregivers for her transfers and had a history of falls.

There was no preliminary services planning and/or negotiated care plan (NCP) for Resident #5 with and identified history of falls and who needed help with mobility and transfers.

The ER said she had 30 days to complete NCP for the resident. She said she did not start to develop NCP for the resident yet. The ER said she was not aware she needed to begin developing a preliminary service plan for the resident.

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, KENNYDALE HILLS AFH LLC is or will be in compliance with this law and / or regulation on (Date) 3/18/16. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.


Provider (or Representative)

4/3/2016
Date

WAC 388-76-10375 Negotiated care plan Signatures Required. The adult family home must ensure that the negotiated care plan is agreed to and signed and dated by the:

- (1) Resident; and
- (2) Adult family home.

This requirement was not met as evidenced by:

Based on record review and interview, the home failed to ensure the negotiated care plans (NCP) of 3 of 5 residents (Residents #2, #3 and #4) had been signed by the residents and the adult family home (AFH) representative. This placed Residents #2, #3 and #4 at risk of unmet care needs and of receiving services the residents did not agree to.

Findings include:

Record reviews and interviews occurred on 3/15/16.

At about 8:30 AM, Resident # 3 sat in his wheelchair. He left the facility to attend day care center for the time of the inspection.

At 9:00 AM, observation found Resident #2 was severely confused and resisted personal care.

Observation found Resident #4 on the living room sofa in front of the TV for the most time of the inspection.

Resident #2

At the entrance interview, the Entity Representative (ER) said Resident #2 was [REDACTED]. The ER said the resident needed medication administration and required two person assistance with her transfer. The ER said the resident had severe cognition impairment and was on a supplemental nutrition.

Record review revealed the home admitted Resident #2 on [REDACTED] 12. The resident or her representative had not signed her 11/15/13 and 11/07/14 NCP. There was no NCP found in the home for Resident #2 for 2015.

On 3/16/16 in an interview, Resident #2's representative said she signed the resident's NCP at the time of her admission to the home.

Resident #3

At the entrance interview, the ER said Resident #3 required assistance with his medication, ambulated with assistance of walker and had cognition impairments.

Record review showed the home admitted Resident #3 on [REDACTED] 14. The resident or his representative did not sign the resident's 10/26/14 NCP. There was no NCP found in the home for Resident #3 for 2015.

Resident #4

Record review revealed the home admitted Resident #4 on [REDACTED] 15. The resident or her representative did not sign the resident's 1/30/16 NCP.

The ER said she was busy and did not review Resident#2, #3 and #4s' NCPs with their representatives.

Attestation Statement

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Provider (or Representative)

4/3/2016
Date

WAC 388-76-10400 Care and services. The adult family home must ensure each resident receives:

(4) Services by the appropriate professionals based upon the resident's assessment and negotiated care plan, including nurse delegation if needed.

This requirement was not met as evidenced by:

Based on observation, interview and record review, the adult family home failed to ensure 1 of 1 resident (Resident #1), who was unable to ask for as needed (PRN) medications, had nurse delegation as required. This placed the resident at risk of medical complications and physical/mental decline in the event he was not given a medication as needed, or was given a PRN medication inappropriately.

Findings include:

Interview and record review occurred on 3/15/16 unless otherwise noted.

At the entrance interview, the Entity Representative (ER) said Resident #1 was [REDACTED] and was [REDACTED] and [REDACTED]. The ER said she administered his as needed (prn) hospice medications.

Records revealed the home admitted Resident #1 on [REDACTED]/12. The resident's 3/07/16 assessment identified him as having physically debilitating conditions, was [REDACTED] requiring total care and administration of his medications.

Medication administration is when medications are administered to the resident by a person legally authorized to do so, such as but not limited to a physician, nurse or pharmacist or through nurse delegation (ND).

Observation found Resident #1 in his bed with [REDACTED] Resident #1 had his eyes closed and did not respond to the licenser questions.

The resident's March 2016 medication log revealed multiple as needed (PRN) hospice medications. The medications included: [REDACTED] with instructions place 4 drops under tongue PRN for [REDACTED] Sulfate (used to treat severe pain) with direction take 5 mg (milligram) under tongue PRN every 4 hours and [REDACTED], 1 mg under tongue PRN every 6 hours prn. The ER initialed she gave the prn medications as follows: [REDACTED] on 3/10/16 and 3/12/16; [REDACTED] two times on 3/12/16, once on 3/13/16, three times on 3/14/16 and once on 3/15/16; she gave [REDACTED] Sulfate three times on 3/14/16 and once on 3/15/16.

According to the Physicians' Desk References website, [REDACTED] sulfate can cause serious breathing problems that can become life-threatening, especially when it is used in the wrong way for long periods of time."

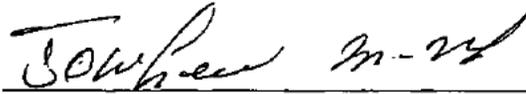
At about 10:35 AM a hospice nurse visited Resident #1. Observation found the hospice nurse gave a verbal orders to the ER. The nurse ordered an increase of the [REDACTED] Sulfaied does from 5 mg to 10 mg. The nurse also ordered an increase in the frequency from every 4 hours to every hour. The ER said "ok." The Licenser intervened and asked the hospice nurse to leave a written order for medication change. The home should be contacting the resident's ND to delegate this task to caregivers. The hospice nurse agreed to contact the home ND.

At about 11:00 AM, observation found March 2016 Resident #1's medication log showed a hand-written "10 mg" next to [REDACTED] Sulfate. The ER's initialed next to the dose.

In interview, when asked if the ND delegated Resident #1's [REDACTED] prn medications to the ER, the ER said "No." The ER said the hospice nurse delegated Resident #1's prn [REDACTED] medications to the ER.

Attestation Statement

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Provider (or Representative)

4 / 3 / 16

Date

WAC 388-76-10430 Medication system.

- (2) When providing medication assistance or medication administration for any resident, the home must ensure each resident:
- (c) Medication log is kept current as required in WAC 388-76-10475 ;
- (d) Receives medications as required.

This requirement was not met as evidenced by:

Based on observations, interviews and record reviews, the adult family home failed to ensure 1 of 2 sampled residents (Resident #5) received her medications as prescribed. Additionally, caregivers initialed medications they did not give, when the home did not update the medication log. This placed Resident #5 at risk of medical complications from medication errors.

Observations, interviews and record reviews occurred on 3/15/16.

At the entrance interview, the Entity Representative (ER) said Resident #5 required assistance with her medications.

March 2016 Residents #5's pharmacy generated medication administration records (MAR) included: Aspirin (blood thinner medication) 81 mg (milligrams) 1 tab (tablet) daily; Ca 600+ Vit (vitamin) D 400 (used to prevent or to treat a calcium deficiency) 1 tab twice a day; [REDACTED] (to help with digestive health) 1 cap (capsule) once a day; Multivit 1 tab once a day; another type of multivit (used to treat or prevent vitamin deficiency) 1 tab once a day; and Vit C 1 tab once a day.

Caregivers initialed they gave the medications daily from 3/01/16- 3/15/16.

Observation found Resident #5's routine medications in a multi-dose bubble pack. There was no Aspirin, Ca 600+ Vit D 400, [REDACTED] two different types of Multivit and Vit C found in the home.

Resident #5's physician note dated 3/09/16 showed Aspirin, Ca 600+ Vit D 400, [REDACTED] two different types of Multivit and Vit C as current medications.

When asked if the home reconciled the resident's medications at the beginning of the month, the ER said "No." When asked where were Resident #5's Aspirin, Ca 600+ Vit D 400, Culturelle,

two different types of Multivit and Vit C, the ER said the resident's family should supply the home with those medications. The ER said the family did not buy the medications. The family said they were "expensive." When asked, if the home notified the resident's doctor, they did not have the medications available, the ER said "No." When asked why caregivers initialed medications they did not give, the ER said it was a mistake. The ER said she had been busy.

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Provider (or Representative)

4/3/16
Date

WAC 388-76-10530 Resident rights Notice of services. The adult family home must provide each resident notice in writing and in a language the resident understands before admission, and at least once every twenty-four months after admission of the:

- (1) Services, items, and activities customarily available in the home or arranged for by the home as permitted by the license;
- (2) Charges for those services, items, and activities including charges for services, items, and activities not covered by the home's per diem rate or applicable public benefit programs; and
- (3) Rules of the home's operations.

This requirement was not met as evidenced by:

Based on interview and record review, the adult family home (AFH) failed to provide 2 of 5 current residents (Resident #1 and #2) written notice of the AFH rules, resident rights, services and activities provided, and the charges for them (Admissions Agreements), every 24 months after admission to the home. This may have resulted in the residents and/or their representative being unaware of house rules, rights, services, and costs.

Findings include:

Interview and record reviews occurred on 3/15/16.

Review of records revealed home admitted Resident #1 on [REDACTED] 12. On [REDACTED] 12. the resident's representative signed the home's initial admission agreements (which included house rules, resident rights, services and activities provided, and charges for them). There were no other admission agreements found in the resident's record.

Review of records revealed the home admitted Resident #2's on [REDACTED] 12. On [REDACTED] 12. the resident's representative signed the home's initial admission agreements. There were no other admission agreements found in the resident's record.

In an interview, the Entity Representative said it was her "mistake."

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* Resident #1 & resident #2 have passed away before I received this letter.



Provider (or Representative)

4/3/16

Date

WAC 388-76-10895 Emergency evacuation drills: Frequency and participation. The adult family home must ensure:

- (1) Emergency evacuation drills occur at least every two months; and
- (2) All residents take part in at least one emergency evacuation drill each calendar year involving full evacuation from the home to a safe location.

This requirement was not met as evidenced by:

Based on observation, interview and record review, adult family home (AFH) failed to ensure they could evacuate 5 of 5 residents from the home every other month. In addition, the home failed to conduct a full emergency evacuation drill of all residents to the safe meeting point outside of the home since October of 2014. Failure to conduct emergency evacuation drills at least every 2 months and a full emergency evacuation drill annually put all 5 residents (Residents #1, #2, #3, #4 and #5) at risk for harm in the event of an actual fire or other emergency requiring evacuation from the AFH.

Findings include:

Observation, interview and record review occurred on 3/15/16.

Five residents were in the home. Observed Resident #1 was [REDACTED] Resident #2, #3, #4 and #5 were in wheelchairs. The AFH staff assisted the residents for mobility. Residents #2 and #4 had severe cognition impairments. Residents #3 and #5 had written behavior plans.

Record review revealed fire drill documentations dated 2/10/16, 11/17/15, 8/15/15, 6/07/15, 4/05/15, 1/03/15 and 10/01/14. There was a three-month interval between emergency evacuation drills 2/10/16 and 11/17/15 and 11/17/15 and 8/15/15. There was no record of fire drills between 2/10/16 and 11/17/15 and/or 11/17/15 and 8/15/15.

Review of fire drill records showed the home last conducted a full evacuation on 10/01/14. There were no other records of a full emergency evacuation drill for the last 12 months found in the home.

In an interview, when asked why the every-two-month emergency evacuation drills were more

than two months apart, the ER said she "did not know." When asked why the home did not conduct the full emergency evacuation from the home at least annually, the ER said she "might did it but marked it as every 2 months." Then, the ER said "I do not know. I will do it in the summer."

Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, KENNYDALE HILLS AFH LLC is or will be in compliance with this law and / or regulation on (Date) 4/1/2016. In addition, I will implement a system to monitor and ensure continued compliance with this cited deficiency.



Provider (or Representative)

4/3/16

Date